CARDIOVASCULAR THERAPY ORDER FORM
P: 240.200.4464 F: 240.892.3005

PATIENT INFORMATION: Fax completed form, insurance information, and clinical documentation to 240.892.3005

Patient Name: ______________________________ DOB: ________________ Phone: ________________________

MEDICAL INFORMATION

Patient Weight: __________ lbs./kg. (required) Allergies: ____

Diagnosis:

- ☐ Hereditary transthyretin-mediated amyloidosis **[E85.82]**
- ☐ Pure hypercholesterolemia, unspecified **[E78.00]**
- ☐ Familial hypercholesteremia **[E78.01]**
- ☐ Mixed hyperlipidemia **[E78.2]**
- ☐ Hyperlipidemia, unspecified **[E78.5]**
- ☐ ASCHD w/o angina pectoris **[I25.10]**
- ☐ Other: ______________________

ICD-10 code: ______________________

THERAPY ORDER

AMVUTTRA (vutrisiran)

- ☐ 25 mg subcutaneously once every 3 months x 1 year

LEQVIO (inclisiran) - *choose one* -

- ☐ 284 mg subcutaneously initially, at 3 months, and then every 6 months (initial start) x 1 year
- ☐ 284 mg subcutaneously every 6 months x 1 year

EVKEEZA (evinacumab-dgnb)

- ☐ 15 mg/kg IV every 4 weeks x 1 year

Please provide the patient's demographic information, insurance information, medication list, and clinical notes. Active Infusions will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and assist them in enrolling in any available co-pay assistance programs as needed/applicable. Thank you for the referral.

PROVIDER INFORMATION

Provider Name: ___________________________ Signature: ___________________________ Date: ___________________

Provider NPI: ____________________ Phone: __________________ Fax: ________________ Contact Person: _____________

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